

WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 4569

FISCAL
NOTE

By Delegates Foggin, Clark, Heckert, Kimble, and

Mazzocchi

[Introduced January 20, 2026; referred to the

Committee on Health and Human Resources]

1 A BILL to amend and reenact §33-15-4s of the Code of West Virginia, 1931, as amended, relating
2 to permitting prior authorization forms to be submitted by fax and providing an effective
3 date.

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.
§33-15-4s. Prior authorization.

1 (a) As used in this section, the following words and phrases have the meanings given to
2 them in this section unless the context clearly indicates otherwise:

3 "Episode of care" means a specific medical problem, condition, or specific illness being
4 managed including tests, procedures, and rehabilitation initially requested by the health care
5 practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That
6 any additional testing or procedures related or unrelated to the specific medical problem,
7 condition, or specific illness being managed may require a separate prior authorization.

8 "National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the
9 NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United
10 States Department of Health and Human Services. Subsequently released versions may be used
11 provided that the new version is backward compatible with the current version approved by the
12 United States Department of Health and Human Services;

13 "Prior authorization" means obtaining advance approval from a health insurer about the
14 coverage of a service or medication.

15 (b) The health insurer shall require prior authorization forms, including any related
16 communication, to be submitted via an electronic portal or fax and shall accept one prior
17 authorization for an episode of care. The portal or fax number shall be placed in an easily
18 identifiable and accessible place on the health insurer's webpage and the portal web address and
19 fax number shall be included on the insured's insurance card. The portal or fax shall:

20 (1) Include instructions for the submission of clinical documentation;

21 (2) Provide an electronic notification to the health care provider confirming receipt of the
22 prior authorization request for forms submitted electronically;

23 (3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment,
24 durable medical equipment, and anything else for which the health insurer requires a prior
25 authorization. The standard for including any matter on this list shall be science-based using a
26 nationally recognized standard. This list shall be updated at least quarterly to ensure that the list
27 remains current;

28 (4) Inform the patient if the health insurer requires a plan member to use step therapy
29 protocols as set forth in this chapter. This shall be conspicuous on the prior authorization form. If
30 the patient has completed step therapy as required by the health insurer and the step therapy has
31 been unsuccessful, this shall be clearly indicated on the form, including information regarding
32 medication or therapies which were attempted and were unsuccessful; and

33 (5) Be prepared by July 1, 2024.

34 (c) Provide electronic communication via the portal or fax regarding the current status of
35 the prior authorization request to the health care provider.

36 (d) After the health care practitioner submits the request for prior authorization
37 electronically, and all of the information as required is provided, the health insurer shall respond to
38 the prior authorization request within five business days from the day on the electronic receipt of
39 the prior authorization request, except that the health insurer shall respond to the prior
40 authorization request within two business days if the request is for medical care or other service for
41 a condition where application of the time frame for making routine or non-life-threatening care
42 determinations is either of the following:

43 (1) Could seriously jeopardize the life, health, or safety of the patient or others due to the
44 patient's psychological state; or

45 (2) In the opinion of a health care practitioner with knowledge of the patient's medical
46 condition would subject the patient to adverse health consequences without the care or treatment

47 that is the subject of the request.

48 (e) If the information submitted is considered incomplete, the health insurer shall identify all
49 deficiencies, and within two business days from the day on the electronic or fax receipt of the prior
50 authorization request return the prior authorization to the health care practitioner. The health care
51 practitioner shall provide the additional information requested within three business days from the
52 time the return request is received by the health care practitioner. The health insurer shall render a
53 decision within two business days after receipt of the additional information submitted by the
54 health care provider. If the health care provider fails to submit additional information, the prior
55 authorization is considered denied and a new request shall be submitted.

56 (f) If the health insurer wishes to audit the prior authorization or if the information regarding
57 step therapy is incomplete, the prior authorization may be transferred to the peer review process
58 within two business days from the day on the electronic or fax receipt of the prior authorization
59 request.

60 (g) A prior authorization approved by a health insurer is carried over to all other managed
61 care organizations, health insurers, and the Public Employees Insurance Agency for three months
62 if the services are provided within the state.

63 (h) The health insurer shall use national best practice guidelines to evaluate a prior
64 authorization.

65 (i) If a prior authorization is rejected by the health insurer and the health care practitioner
66 who submitted the prior authorization requests an appeal by peer review of the decision to reject,
67 the peer review shall be with a health care practitioner, similar in specialty, education, and
68 background. The health insurer's medical director has the ultimate decision regarding the appeal
69 determination and the health care practitioner has the option to consult with the medical director
70 after the peer-to- peer consultation. Time frames regarding this peer-to-peer appeal process shall
71 take no longer than five business days from the date of the request of the peer-to-peer
72 consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no

73 longer than 10 business days from the date of the appeal submission.

74 (j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior
75 authorization may not be subject to prior authorization requirements and shall be immediately
76 approved for not less than three days: *Provided*, That the cost of the medication does not exceed
77 \$5,000 per day and the physician shall note on the prescription or notify the pharmacy that the
78 prescription is being provided at discharge. After the three-day time frame, a prior authorization
79 shall be obtained.

80 (2) If the approval of a prior authorization requires a medication substitution, the
81 substituted medication shall be as required under §30-5-1 *et seq.* of this code.

82 (k) If a health care practitioner has performed an average of 30 procedures per year and in
83 a six-month time period during that year has received a 90 percent final prior approval rating, the
84 health insurer may not require the health care practitioner to submit a prior authorization for at
85 least the next six months, or longer if the insurer allows: *Provided*, That at the end of the six-month
86 time frame, or longer if the insurer allows, the exemption shall be reviewed prior to renewal. If
87 approved, the renewal shall be granted for a time period equal to the previously granted time
88 period, or longer if the insurer allows. This exemption is subject to internal auditing, at any time, by
89 the health insurer and may be rescinded if the health insurer determines the health care
90 practitioner is not performing services or procedures in conformity with the health insurer's benefit
91 plan, it identifies substantial variances in historical utilization, or identifies other anomalies based
92 upon the results of the health insurer's internal audit. The insurer shall provide a health care
93 practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in
94 this subsection may be interpreted to prohibit an insurer from requiring a prior authorization for an
95 experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network
96 service or procedure.

97 (l) This section is effective for policy, contract, plans, or agreements beginning on or after
98 January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to

99 this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or
100 after the effective date of this section.

101 (m) The Insurance Commissioner shall request data on a quarterly basis, or more often as
102 needed, to oversee compliance with this article. The data shall include, but not be limited to, prior
103 authorizations requested by health care providers, the total number of prior authorizations denied
104 broken down by health care provider, the total number of prior authorizations appealed by health
105 care providers, the total number of prior authorizations approved after appeal by health care
106 providers, the name of each gold card status physician, and the name of each physician whose
107 gold card status was revoked and the reason for revocation.

108 (n) The Insurance Commissioner may assess a civil penalty for a violation of this section
109 pursuant to §33-3-11 of this code.

110 (o) The amendments to this section made during the 2026 regular legislative session are
111 effective from passage.

NOTE: The purpose of this bill is to permit prior authorization forms to be submitted via fax.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.